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13c. Preventive services.

A. Maternity length of stay and early discharge.

1. If the mother and newborn, or the newborn alone, is discharged earlier than 48 hours after the day of delivery, DMAS will cover one early discharge follow-up visit as recommended by the physicians in accordance with and as indicated by the most current version of or an official update to the "Guidelines for Perinatal Care" as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (1992, as amended). The mother and newborn, or the newborn alone, if the mother has not been discharged, must meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge follow-up visit does not affect or apply to any usual postpartum or well-baby care or any other covered care to which the mother or newborn is entitled; it is tied directly to an early discharge.

2. The early discharge follow-up visit must be provided as directed by a physician. The physician may coordinate with the provider of their choice to provide the early discharge follow-up visit, within the following limitations. Qualified providers are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

12 VAC 30-50-225.

13d. Rehabilitative services.

A. Intensive physical rehabilitation:

1. Medicaid covers intensive inpatient rehabilitation services as defined in §A.4 in facilities certified as rehabilitation hospitals or rehabilitation hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in §A.4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21 day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive physical rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

6. To receive continued intensive rehabilitation services, the patient must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team. This shall be evidenced by regular attendance in planned activities and demonstrated progress toward the established goals.

7. Intensive rehabilitation services shall be considered for termination regardless of the preauthorized length of stay when any of the following conditions are met:

a. No further potential for improvement is demonstrated. The patient has reached his maximum progress and a safe and effective maintenance program has been developed.

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b. There is limited motivation on the part of the individual or caregiver.

c. The individual has an unstable condition that affects his or her ability to participate in rehabilitative plan.

d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time.

e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.

f. The service can be provided by someone other than a skilled rehabilitation professional.

12 VAC 30-50-226.

B. Community Mental Health Services.

Definitions. The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

"Code" means the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services consistent with the Code of Virginia Chapter 10, Title 32.1, §§32.1-323 et seq.

"DMHMRSAS" means Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with the Code of Virginia Chapter 1, Title 37, §37.1-39 et seq.

"Individual" means the patient, client, or recipient of services set out herein.

"Individual service plan" or "ISP" means a comprehensive and regularly updated statement specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, estimated timetable for achieving the goals and objectives. Such ISP shall be maintained up to date as the needs and progress of the individual changes.

1. Mental health services. The following services, with their definitions, shall be covered:

a. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities

designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment.

b. Psychosocial rehabilitation shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about his mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

c. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, pre-admission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

d. Intensive community treatment (ICT), initially covered for a maximum of 26 weeks based on an initial assessment with continuation reauthorized for an additional 26 weeks annually based on written assessment and certification of need by a QMHP, shall be defined as medical psychotherapy, psychiatric assessment, and medication management offered to outpatients outside the clinic, hospital, or office setting for individuals who will not or cannot be served in the clinic setting.

e. Crisis stabilization services for non-hospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community_living situation. Authorization may be for up to a 15 day period per crisis episode following a documented face-to-face assessment by a QMHP which is reviewed and approved by a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or a certified psychiatric registered nurse within 72 hours. The maximum limit on this service is up to eight hours (with a unit being one hour) per day up to 60 days annually. The goals of crisis stabilization programs shall be to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement. The crisis stabilization program shall provide to recipients, as appropriate: psychiatric assessment including medication evaluation,

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treatment planning; symptom and behavior management; and individual and group counseling. This service may be provided in any of the following settings, but shall not be limited to: (i) the home of a recipient who lives with family or other primary caregiver; (ii) the home of a recipient who lives independently; or (iii) community-based programs licensed by DMHMRSAS to provide residential services but which are not institutions for mental disease (IMDs).

f. Mental health support services shall be defined as training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services may be authorized for six consecutive months. Continuation of services may be authorized at six month intervals or following any break in service by a QMHP based on a documented assessment and documentation of continuing need. The monthly limit on services shall be 31 units. This program shall provide the following services in order to be reimbursed by Medicaid: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management and monitoring health, nutrition, and physical condition.

12 VAC 30-50-227.

2. Mental retardation (MR) services/Related Conditions. *Repealed.*

12 VAC 30-50-229.

C. Lead contamination. Coverage shall be provided for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Only costs that are eligible for federal funding participation in accordance with current federal regulations shall be covered. Payments for environmental investigations under this section shall be limited to no more than two visits per residence.

12 VAC 30-50-230.

14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

A. Provided, no limitations.

14b. Skilled nursing facility services.

A. Provided, no limitations.

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12 VAC 30-50-229.1. School health services.

A. School health services shall be defined as those therapy and nursing services rendered by school divisions which are enrolled with DMAS to serve children who qualify to receive special education services as described under Part B of the federal Individuals with Disabilities Education Act, as amended (20 USC § 1400 et seq.). Children qualifying for special education services pursuant to Part B of the federal Individuals with Disabilities Education Act, as amended, shall not be restricted in their choice of enrolled providers of medical care services as described in the State Plan for Medical Assistance.

B. Physical therapy and related services.

1. The services covered under this subsection shall include physical therapy, occupational therapy, and speech/language pathology services. All of the requirements of 12 VAC 30-50-200 and 42 CFR 440.110 applicable to these services shall continue to apply with regard to, but not necessarily limited to, necessary authorizations, documentation requirements, provider qualifications, and service limitations.

2. Consultation by physical therapy, occupational therapy, or speech pathology providers in meetings for the development, evaluation, or reevaluation of the Individualized Education Program (IEP) for specific children shall be covered when the IEP with the physical therapy, occupational therapy, or speech pathology services is implemented (based on the date of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations may be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by either registered nurses or licensed practical nurses. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.

3. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the physical therapy, occupational therapy, or speech pathology services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include, but shall not be limited to, arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.

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C. Skilled nursing services.

1. These must be medically necessary skilled nursing services which are required by a child in order to benefit from an educational program, as described under Part B of the federal Individuals with Disabilities Education Act, as amended (20 USC § 1400 et seq.). These services shall be limited to a maximum of six units a day of medically necessary services. Services not deemed to be medically necessary, upon utilization review, shall not be covered. A unit, for the purposes of this school-based health service, shall be defined as 15 minutes of medical care.

2. These services must be performed by a Virginia-licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN. The service provider shall be either employed by the school division or under contract to the school division. The skilled nursing services shall be rendered in accordance with the licensing standards and criteria of the Virginia Board of Nursing. Supervision of LPNs shall be provided consistent with the regulatory standards of the Board of Nursing at 18 VAC 90-20-270.

3. Consultation by skilled nursing providers in meetings for the development, evaluation, or reevaluation of the IEP for specific children shall be covered when the IEP with the skilled nursing services is implemented (based on the dates of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations may be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by physical therapists, occupational therapists, and speech therapists. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.

4. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the skilled nursing services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include but shall not be limited to arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.

5. The services shall be of a level of complexity and sophistication which are consistent with skilled nursing services. These skilled nursing services shall include, but not necessarily be limited to, dressing changes, maintaining patent airways, and urinary catheterization

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6. Skilled nursing services shall be directly and specifically related to an active, written plan of care, which is based on a physician's or nurse practitioner's written order for skilled nursing services. The Registered Nurse is to establish, sign, and date the plan of care. The plan of care is to be periodically reviewed by a physician or nurse practitioner, after any needed consultation with skilled nursing staff. The services shall be specific and provide effective treatment for the child's condition in accordance with accepted standards of skilled nursing practice. The plan of care is further described in subdivision 7 of this subsection. Skilled nursing services rendered which exceed the physician or nurse practitioner written order for skilled nursing services shall not be reimbursed by DMAS. A copy of the POC shall be given to the child's Medicaid primary care provider.

7. Documentation of school-based skilled nursing services. Documentation of services shall include a written POC which identifies the medical condition or conditions to be addressed by skilled nursing services, goals for skilled nursing services, time tables for accomplishing such stated goals, actual skilled nursing services to be delivered and whether the services will be delivered by an RN or LPN. Services which have been delivered and for which reimbursement from Medicaid is to be claimed must be supported with like documentation. Documentation shall include the dates and times of services entered by the responsible licensed nurse; the actual nursing services rendered; the identification of the child on each page of the medical record; the current diagnosis and elements of the history and exam which form the basis of the diagnosis; any prescribed drugs which are part of the treatment including the quantities and dosage; and notes to indicate progress made by the child, changes to the diagnosis or treatment and response to treatment. The Plan of Care is to be part of the child's medical record. Actions related to the skilled nursing services such as notifying parents, calling the physician, or notifying emergency medical services shall also be documented. All documentation shall be signed and dated by the person performing the service. The documentation shall be written immediately, or as soon thereafter as possible, after the procedure or treatment was implemented with the date and time specified, unless otherwise instructed in writing by Medicaid. Documentation is further described in the Medicaid school services manual. Skilled nursing services documentation shall otherwise be in accordance with the Virginia Board of Nursing, Department of Health, and Department of Education statutes, regulations, and standards relating to school health. Documentation shall also be in accordance with school division standards.

8. Service limitations. The following general conditions shall apply to reimbursable skilled nursing services in school divisions:

   a. Patient must be under the care of a physician or nurse practitioner who is legally authorized to practice and who is acting within the scope of his license.

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b. A recertification by a physician or nurse practitioner of the skilled nursing services shall be conducted at least once each school year. The recertification statement must be signed and dated by the physician or nurse practitioner who reviews the plan of care, and may be obtained when the plan of care is reviewed. The physician or nurse practitioner recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

c. Physician or nurse practitioner orders for skilled nursing services shall be required.

d. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the child's school medical record as having been rendered shall be deemed not to have been rendered and no payment shall be provided.

e. Skilled nursing services are to be terminated when further progress toward the treatment goals are unlikely or when they are not benefiting the child or when the services can be provided by someone other than the skilled nursing professional.

12 VAC 30-50-230.

14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

A. Provided, no limitations.

14b. Skilled nursing facility services.

A. Provided, no limitations.

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14c. Intermediate care facility.

A. Provided, no limitations.

15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902 (a)(31)(A) of the Act, to be in need of such care.

A. Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

A. Provided, no limitations.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

A. Not provided.

17. Nurse-midwife services.

A. Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

18. Hospice services (in accordance with §1905 (o) of the Act).

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.